HIV Care Services Contractor Guidelines

2013

Division of Disease Prevention

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

COMMONWEALTH of VIRGINIA

Department of Health

CYNTHIA C. ROMERO, MD, FAAFP
STATE HEALTH COMMISSIONER

PO BOX 2448
RICHMOND, VA 23218

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Foreword and Acknowledgements

The HIV Care Services (HCS) Unit of the Division of Disease Prevention (DDP) updates these guidelines annually to provide current information and support to our contractors. This document is intended to guide invoicing, reporting, contracting activities, and quality management (QM) practices. We hope this resource serves as a helpful reference.

You who contract and subcontract with HCS are valued partners in the provision of HIV related services, providing a remarkable array of services and support across the state. With diligence, hard work and dedication, contractors and subcontractors play the most critical role in providing services to people living with HIV and AIDS. You serve as a vital link in ensuring the delivery of medical, medication access and many other services. As we strive to improve service provision and systems of access in Fiscal Year 2013, we look forward to your collaboration.

I would like to thank those who contributed to this document, including the members of the HCS and Fiscal staff, and the many contractors and subcontractors that have provided feedback to improve the usefulness of it. If you have any questions about its contents, please contact your HIV Services Coordinator or any member of the HCS staff.

Sincerely,

Steven S. Bailey, LCSW
Director of HIV Care Services
Division of Disease Prevention
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ATTACHMENTS

What is the Ryan White HIV/AIDS Program?

Ryan White was diagnosed with AIDS at age 13. He and his mother Jeanne White Ginder fought for his right to attend school, gaining international attention as a voice of reason about HIV/AIDS. At the age of 18, Ryan White died on April 8, 1990, just months before Congress passed the AIDS bill that bears his name – the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act. The legislation has been reauthorized four times since – in 1996, 2000, 2006, and 2009 – and is now called the Ryan White HIV/AIDS Program.

The Ryan White HIV/AIDS Treatment Extension Act of 2009 Part B funding is intended to help states increase the availability of primary health care and support services in order to reduce utilization of more costly inpatient care, increase access to care for underserved populations, and improve the quality of life of those affected by the epidemic.

The Ryan White HIV/AIDS Program is the largest Federal program focused exclusively on HIV/AIDS care. The program is for those who do not have sufficient health care coverage or financial resources for coping with HIV disease. Ryan White fills gaps in care not covered by these other sources.

The Ryan White HIV/AIDS Program is administered by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), and HIV/AIDS Bureau (HAB). For a thorough understanding of Ryan White legislation, you can visit the HRSA HAB website at: http://hab.hrsa.gov

The 2009 Ryan White legislation changed how Ryan White funds can be used, with an emphasis on providing life-saving and life-extending services for people living with HIV/AIDS across the country. Key changes included:

- Revised method for determining eligibility for Part A funds gives priority to urban areas with the largest number of people living with HIV/AIDS while also helping mid-size cities and areas with emerging needs.

- Revised method for distributing Part A funds to metropolitan areas with the highest number of people living with HIV/AIDS. This encourages outreach and testing, which will get people into treatment sooner and save more lives.

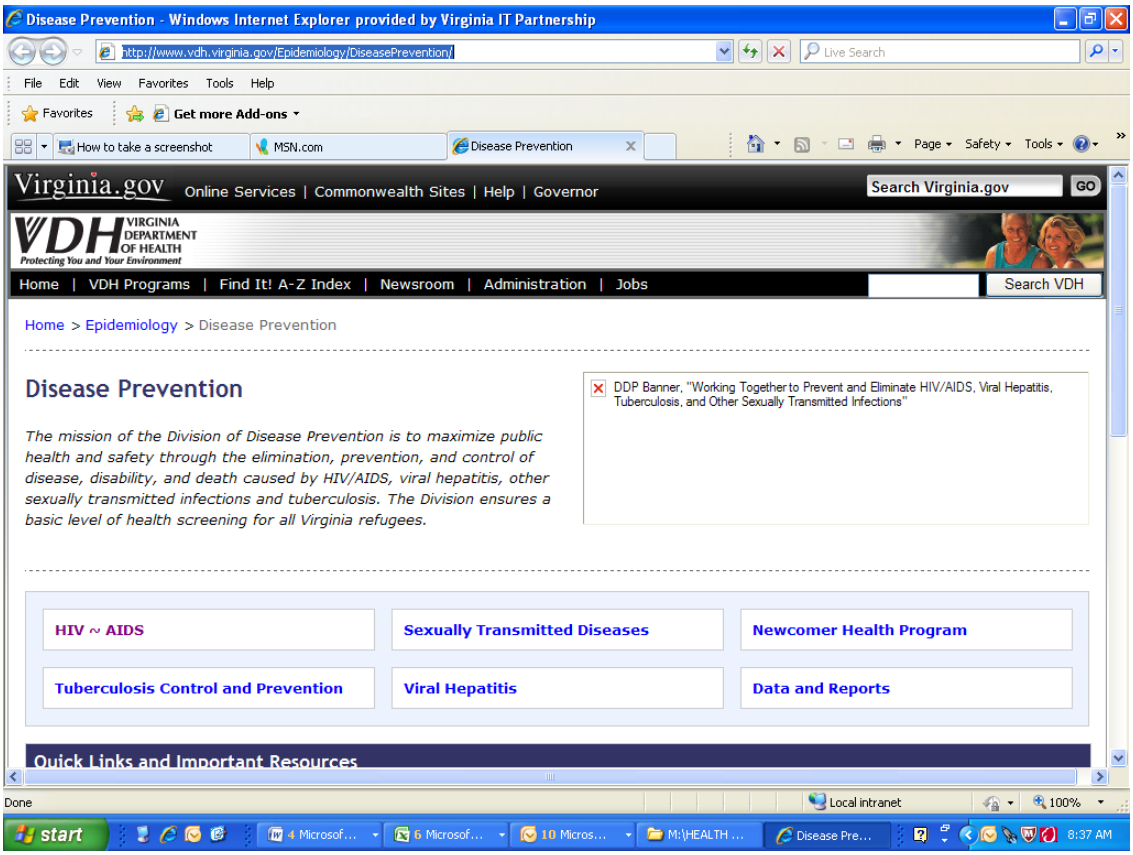
- More money will be spent on direct health care for Ryan White clients. Under the 2009 law, grantees receiving funds under Parts A, B, and C must spend at least 75% of funds on core medical services.

- The 2009 law recognizes that HIV/AIDS has had a devastating impact on racial/ethnic minorities in the U.S. African Americans accounted for approximately half of all diagnosed HIV/AIDS cases. The 2006 law codified the Minority AIDS Initiative (MAI) under the Ryan White HIV/AIDS Program.

- Of primary importance is the provision that states must spend or obligate 95% or more of their grant award from HRSA. States with 5% or more of their grant funds unobligated at the close of the grant year will have future grant awards reduced by the amount of the unspent balance. Contractors and subcontractors should closely monitor their budgets to make every effort to spend allocated funds.

Virginia receives funds to improve the quality, availability, and organization of health care and support services for individuals living with HIV disease and their families. The Department of Health oversees the implementation and funding for the Ryan White Part B (RWB) program in Virginia under the guidance of HRSA. These funds are managed by the HCS Unit of the DDP.

The DDP Web site http://www.vdh.virginia.gov/Epidemiology/DiseasePrevention/ provides a thorough overview of the mission and scope of services provided with and by RWB funding. On this site, you can review a map of the Health Regions, obtain fact sheets, order printed materials, view statistics on sexually transmitted diseases including HIV, and/or get detailed information on all programs that are currently managed by the DDP. Details of specific programs can be accessed through the "Our Programs" link on the Division homepage. Visiting the link titled "HIV Care Services" is highly recommended.



VIRGINIA DEPARTMENT OF HEALTH DIVISION OF DISEASE PREVENTION
HIV CARE SERVICES TEAM

Staff Name	Title	Business Phone
Ahmed, Amina	Services Data Manager	804-864-7938
Allen, Diane	HIV Care Services	804-864-8019
Alston, Jamaal	Health Claims Specialist	804-864-7213
Anthony, Rishelle	ADAP Data Manager	804-864-7216
Bailey, Steven	Director, HIV Care Services	804-864-8065
Browder, Mary	HIV Care Services	804-864-7199
Brown, Daryle	HIV Care Services	804-864-8164
Clarke, Marlene	HIV Care Services	804-864-7950
Diawara, Safere	Asst. Director, HIV Care Services	804-864-8021
Eley, Kimberly	HIV Care Services	804-864-8018
Flannagan, Jennifer	HIV Care Services	804-864-7360
Ford, Darby	HIV Care Services	804-864-7411
Gilmore, Kathryn	HIV Care Services	804-864-8014
Hair, Bengie	Asst. Director, Med. Access	804-864-7174
Hilton, Krystal	HIV Care Services	804-864-7228
Horner, Francis (Scott)	HIV Care Services	804-864-7546
Isayev, Daniela	HIV Care Services	804-864-7646
Lombardi , Lenore	HIV Care Services	804-864-8022
Naranjo, Veronica	HIV Care Services	804-864-7919
Rector, Jeannie	Admin. Asst, HIV Care Services	804-864-7965
Recupero, Lenny	HIV Care Services	804-864-7410
Rhodes , Anne	HIV Care Services	804-864-8013
Rhodes, Carrie	HIV Care Services	804-864-7914
Robertson , Hunter	HIV Care Services	804-864-7412
Smith, Lekesha	HIV Care Services	804-864-7958
Smith, Miranda	HIV Care Services	N/A
Young, Lloyd	HIV Care Services	804-864-7621

General Contact Numbers

HIV Care Services	(804) 864-7965
ADAP Medication Eligibility Hotline (Toll Free)	(855) 362-0658
DDP HIV/AIDS Hotline	(800) 533-4148
Jeannie Rector, Administrative Assistant	(804) 864-7965
Wendy Howard-Cooper, Business Manager	(804) 864-8213

Fax Numbers

HIV Care Services	(804) 864-7629
ADAP	(804) 864-8050

RYAN WHITE PART B MINORITY AIDS INITIATIVE

The Virginia Department of Health (VDH) receives funds under the Ryan White HIV/AIDS Treatment Extension Act of 2009 Part B Minority AIDS Initiative (MAI) Grant Program to provide case-finding, outreach and education services to increase access to HIV primary health care, the AIDS Drug Assistance Program (ADAP) and other prescription drug coverage for racial and ethnic minorities. Community-based organizations and health districts focus on identifying and referring individuals at risk for or infected with HIV in order to link them into ADAP or other medication sources, and those HIV-positive individuals who have been lost-to-care in order to re-engage them in ADAP and other needed care services. Linkage to medical care is supported by additional Part B funds to ensure complete access to treatment. MAI funded Patient Navigators in the Southwest region are trained to provide "HIV Rapid Testing".

Centra Health, Inc. (Southwest region) and Inova Juniper Program (Northern region) are the two agencies providing MAI programming for 2013-2014.

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PO Box 2448, Room 326, Richmond, Virginia 23218
Street Address: 109 Governor Street,
Richmond, Virginia 23219-2448
Phone # (804) 864-7950
Fax # (804) 864-8050
ATTN: **Lenore Lombardi, Lead HIV Services Coordinator**
Email: lenore.lombardi@vdh.virginia.gov

STATE EARLY INTERVENTION PROGRAMS (EIPS)

VDH receives funds from the State General Assembly to support HIV Early Intervention Programs in Central and Southwest Virginia. Continued funding for Early Intervention Programs (EIPs) ensures that individuals with HIV infection enter care as early as possible in their disease process. The EIPs strategically utilize these funds to improve or maintain access to HIV care and services. These programs not only provide treatment and counseling to clients to enable them to remain healthy and productive as long as possible, but also provide supportive care during the difficult psychological period after initial diagnosis of HIV infection. In addition, EIPs enable clients to improve their health and remain adherent to their anti-retroviral medication regimen, which is critical to quality of life. These programs also provide case management services that help newly-diagnosed clients apply for Medicaid, Medicare Part D, Social Security disability and/or supportive services

Arthur Ashe Program (AAP)
Virginia Commonwealth University (VCU) Health System
PO Box 980049, Richmond, Virginia 23298
Street Address: 1101 E. Street, MCV Station,
Richmond, Virginia 23298-0049
Phone # (804) 230-2087
Fax # (804)230-2071
ATTN: **Dr. Veronica Ayala-Sims, M.D.,**
Email: vaayalas@vcu.edu

Central Virginia Health District (CVHD)
PO Box 6056, Lynchburg, Virginia 24505
Street Address: 1900 Thomson Drive,
Lynchburg, Virginia 24505
Phone # (804) 947-6777
ATTN: **Dr. Katherine V. Nichols, M.D., District Director**
Email: Katherine.Nichols@vdh.virginia.gov

Fan Free Clinic (FFC)
Fan Free Clinic
PO Box 6477, Richmond Virginia 23230
Street Address: 1010 N. Thompson Street
Richmond, Virginia 23230
Phone # (804)358-6343
ATTN: **Karen Legato, Executive Director**
Email: KLegato@fanfreeclinic.org

RYAN WHITE PART B AIDS DRUG ASSISTANCE PROGRAM

Program Overview. The Virginia AIDS Drug Assistance Program (ADAP) provides HIV medication to low income persons living with HIV who have no medication coverage from private or third party insurance, including Medicaid, Medicare Part D (MPAP), Pre-existing Condition Insurance Program (PCIP), and private insurance plans (individual or employer-based). The Virginia ADAP is funded by Ryan White Part B and State funds. These fiscal resources are always considered to be the payer of last resort to pay for medications. In Virginia, medications are available for eligible clients by: (1) medication pick-up at a local health department (LHD) or other designated sites as dispensed through the Central Pharmacy, and (2) through MPAP and PCIP at over 1,100 retail pharmacies in the state. All states and territories receive funding for State ADAP Programs from the Ryan White Treatment and Modernization Act of 2009. The best resource for information regarding Virginia ADAP is the ADAP website: www.vdh.virginia.gov/ADAP

1) Direct Medication Provision

The program is administered centrally through the Virginia Department of Health (VDH), with medications made available at all LHDs, Virginia Commonwealth University Health System (VCUHS), and Inova Juniper locations in Northern Virginia. VDH's Central Pharmacy purchases and dispenses ADAP medications for all LHDs' ADAP clients with the exception of Fairfax County and Alexandria Health Departments. Fairfax County and Alexandria are provided bulk ADAP medications from Central Pharmacy Services and dispense individual medications locally from in-house pharmacies. VCUHS purchases and stocks medications and VDH Central Pharmacy replenishes medications as needed. For all other sites, prescriptions are ordered through Central Pharmacy Services by LHD staff upon presentation of an ADAP Formulary prescription by an ADAP eligible consumer. The Central Pharmacy fills prescription orders and ships back to the LHDs on a daily basis. Clients come to the LHDs to pick up their medications. The LHD may require a consumer to verify their identity for the medication to be dispensed. This delivery system ensures that all clients in the state have access to medications, as LHDs are located throughout every area of the state.

2) Medicare Part D Assistance Program (MPAP)/ Formerly the State Pharmaceutical Assistance Program (SPAP).

Ramsell, VDH's pharmacy benefits manager, manages the Medicare Part D Assistance Program (MPAP) for Virginia. MPAP provides financial support towards medication co-payments, deductibles, and premiums associated with a Medicare Part D plan for eligible individuals with income less than 400% of the federal poverty level (FPL). MPAP replaces Virginia's State Pharmaceutical Assistance Program (SPAP). Historically, SPAP utilized state funds only. MPAP, however, utilizes a variety of funding sources including, but not limited to, pharmaceutical rebates, federal funds and state funds. One application may be submitted for ADAP and MPAP as eligibility criteria is the same for both programs. An application can be

submitted for either program by calling the ADAP Medication Eligibility Hotline at 1-855-362-0658. In order for a client to be eligible for MPAP, they must be enrolled into Medicare A or B and have a Part D plan. The ADAP website will reflect current programmatic information and eligibility criteria.

3) Pre-existing Condition Insurance Plan – PCIP

The Pre-Existing Condition Insurance Plan (PCIP) was enacted nationally in 2010 as a part of the Affordable Care Act (ACA). The PCIP program was designed to make health insurance available to individuals that had been denied coverage by private insurance companies because of a pre-existing condition. PCIP is a transitional program until January 2014 when other insurance coverage is scheduled to be available. PCIP eligibility is not based on income, but on the following three criteria:

- U.S. citizen or a legal resident
- Have a pre-existing medical condition
- Not have been covered under creditable health coverage (as defined by Section 201(c)(1) of the Public Health Service Act) for the previous six months before applying for coverage

In early 2013, Virginia ADAP implemented a Pre-existing Condition Insurance Program (PCIP) and was able to enroll approximately 450 HIV consumers statewide before enrollment was suspended by the federal government on February 15, 2013. PCIP co-payments are managed for VDH by Ramsell, our pharmacy benefits manager (PBM). All persons enrolled in PCIP are subject to ADAP enrollment qualifications, program criteria, eligibility, and re-certification every six months. Additional information may be obtained by calling the ADAP Medication Eligibility Hotline at 1-855-362-0658.

ADAP Eligibility:

Except for clients accessing ADAP through VCUHS, VDH is responsible for all ADAP eligibility determinations and ADAP re-certifications throughout the Commonwealth of Virginia. Based on Ryan White Program guidelines, re-certification for ADAP occurs every six months. Currently the ADAP financial eligibility is based on 400% of the federal poverty level (FPL). The ADAP website is the best resource for up-to-date eligibility criteria.

- Eligibility: http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/eligibility.htm

ADAP Formulary:

The formulary document includes the criteria required for each medication. Some medications on the formulary require additional medical criteria. If a clinician desires to prescribe any of these medications, an ADAP Medication Exception Form should be completed and submitted to Virginia ADAP for review and authorization. A copy is located in the Attachment Section, Attachment #A-8.

Medications are dispensed from the VDH Central Pharmacy to the local health departments (LHDs) for client pick up. In addition to LHDs, ADAP clients may also pick-up medications at VCUHS, Alexandria Health Department/Casey Clinic, Fairfax Health Department/Joseph

Willard Health Center and Inova Juniper Program sites in Herndon, Leesburg, Springfield, Manassas and Dumfries. All new and returning applicants to ADAP must complete an application with VDH, with the exception of clients accessing medication through (VCUHS).

- Formulary: http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/formulary.htm

Policy Updates:
ADAP policy updates, including new medications to the ADAP Formulary, are routinely published and made available on the ADAP website. These updates are targeted towards clinical providers, program staff, and new residents to Virginia seeking ADAP services. Each policy update is subject specific and is posted as approved for public communication. Please visit the ADAP update page periodically to review the policy updates: http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/updates.htm.

ADAP Program Contact Information:

Virginia Department of Health (VDH)
PO Box 2448, Room 326, Richmond, Virginia 23218
Street Address: 109 Governor Street,
Richmond, Virginia 23219-2448
Phone # (855) 362-0658
Fax # (804) 864-8050

SEAMLESS TRANSITION PROGRAM

The overall goal for this program is to provide a seamless transition in relation to HIV/AIDS medical care and medications access for persons released from state correctional facilities as they re-enter Virginia communities. Discharge plans are made prior to the release date of the inmate to ensure continuation of medical care and medications access.

The Virginia Department of Corrections faxes the inmates release information to VDH Care Coordinators who coordinate medication access. Care Coordinators fax a medication request form to the Virginia Commonwealth University Health System (VCUHS). Care Coordinators facilitate receipt of prescriptions from VDH Central Pharmacy and medication access for clients at their local health departments.

Virginia Department of Health (VDH)
PO Box 2448, Room 326, Richmond, Virginia 23218
Street Address: 109 Governor Street,
Richmond, Virginia 23219-2448
Phone # (804) 864-7219 or (804) 864-7919
Toll Free ADAP Medication Eligibility Hotline #1-855-362-0658
Fax # (804) 864-8050
ATTN: **Veronica Naranjo, HIV Care Coordinator**
Email: Milagritos.Flinn@vdh.virginia.gov
Veronica.Naranjo@vdh.virginia.gov

SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE (SPNS)
SYSTEMS LINKAGES AND ACCESS TO CARE INITIATIVE

In 2011, the VDH received a four-year grant from the U.S. Health Resources and Services Administration (HRSA) to implement a Special Project of National Significance (SPNS), Systems Linkages and Access to Care for Populations at High Risk of HIV Infection. This initiative is designed to demonstrate improvements in access to and retention in high quality, competent HIV care and services for hard-to-reach populations of HIV-infected persons who are unaware of their status, have never been in care, or who have dropped out of care. The overall goals of this project are to increase the percentage of newly-diagnosed clients who engage in care within three months post-diagnosis, to increase the retention rate in care, and to develop a referral system maximizing funding and linkage resources while coordinating and streamlining client services. VDH is one of seven demonstration states that have been funded for this initiative.

In Virginia, this project consists of four critical components of the HIV care system. First, an active referral process will be implemented allowing Disease Intervention Specialists (DIS) and testing and referral agencies to ensure clients are rapidly linked to care upon diagnosis. Second, Patient Navigators will assist clients in engagement and retention in the treatment process, linking them to care and available resources. Third, newly-established Care Coordinators will work with the Virginia Department of Corrections and other community re-entry programs to coordinate care and services for recently released HIV-positive inmates. Finally, the project will develop a comprehensive assessment, referral, and treatment system, addressing the mental health needs towards increasing retention in HIV care and improving HIV and mental health care outcomes. These strategies are currently being piloted and will be more widely implemented across other regions and sites in Years 3 and 4 of the initiative.

The combination of these approaches will help increase client linkage and retention in the health care system. Collaboration is ongoing at the state and local level throughout the implementation of the initiative. Coordination of staff from the VDH central office will involve Field Services, HIV Prevention Services (HPS), Health Informatics & Integrated Surveillance Systems (HIISS), as well as HCS work units to provide project support and technical assistance for locally funded contractors and DIS throughout the duration of the project implementation and evaluation.

HCS SPNS Program Coordinator
Kate M. Gilmore, (804) 864-8014, Kathryn.Gilmore@vdh.virginia.gov

Virginia Department of Health (VDH)
PO Box 2448, Room 326, Richmond, Virginia 23218
Street Address: 109 Governor Street,
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Phone # (804) 864-7965

RYAN WHITE PART B STATEWIDE QUALITY MANAGEMENT PROGRAM

The mission of the VDH QM Program is to promote continuous quality improvement by meeting the RW HIV/AIDS Treatment Extension Act of 2009 requirements for QM. These requirements include: 1) measuring how well HIV health services meet the most recent Public Health Service (PHS) Guidelines, and 2) developing strategies for improving access to quality HIV health services. The VDH QM Program envisions optimal health for all people affected by HIV/AIDS, supported by a health care system that assures ready access to comprehensive, competent, quality care that transforms lives and communities. This effort requires ongoing communication with consumers, employees, stakeholders, consortia, contractors, subcontractors, Quality Management Advisory Committee (QMAC), Quality Management Leadership Team (QMLT), Peer Review Team, providers and all levels of management.

The overarching purpose of the QM efforts are to: ensure the highest quality care is provided to clients; prevent, identify, and solve problems over time through continuous performance measurement; enable monitoring of HIV-related illnesses and trends in the local epidemic through use of demographic, clinical and service utilization data; assess consumer needs; build QM capacity within RWB-funded agencies statewide and monitor and evaluate key indicators and measures to detect trends; and identify opportunities to improve quality of care and delivery of services.

Fourteen selected performance measures (PMs) and indicators will be monitored and measured in 2013 at state and local levels and will be integrated into the annual QM Plan for FY 2013. Eleven of these selected measures were previously monitored, in the areas of Outpatient Care, Medical Case Management and the ADAP. The additional three are Dental Care measures where baseline indicators will be determined through FY 2013 monitoring. Data from these reports will be used by the statewide QMAC to plan, design, measure, assess, and improve services and processes within RWB activities.

VDH will implement formal regional trainings in 2013 for contractors and subcontractors based on identified QM issues. Additionally, skills-building sessions will be continually developed to provide a wide range of learning opportunities related to QM for RWB providers. Throughout much of FY 2013, VDH will be convening a Case Management (CM) Improvement Initiative Taskforce to examine and offer recommendations to revise the current CM service delivery model. This revision will include the updating of standards assessment modules and will also entail a CM training program for all Virginia HIV CM service providers.

VDH will continue to participate in the HRSA-funded Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) project for the fifth year and will work with the Eastern Virginia Medical School (EVMS) PSPC Team to work toward improving patient health outcomes,

resolving poly-pharmacy problems, and co-locating pharmacy services. During FY 2012, VDH merged its quality advisory committee, QMAC, with the Virginia RW QM Cross-Parts Collaborative. Active participation in the DC EMA QM Cross-Parts Collaborative will continue to be a VDH quality priority.

In accordance with HRSA policy, RW-funded providers, subcontractors and direct contractors are required by VDH to develop, submit and implement their 2013 QM plans with measurable objectives. Progress made in developing QM plans and in reaching identified outcomes will be monitored by the Quality Management Coordinator and HIV Services Coordinators.

VDH has established three distinct processes to continuously monitor the QM program. **First,** all funded agencies receive annual site visit reviews. To supplement the statewide PR information, HCS staff conducts annual site visits to each consortium lead agency and each direct contractor. Additionally, consortia lead agencies conduct site visits to their subcontractors on a continuous basis with the participation of VDH representatives during at least one annual subcontractor site visit. **Second,** statewide regional and agency client satisfaction/Needs Assessment surveys are conducted to determine client satisfaction levels, identify additional client needs, and isolate trends to identify opportunities for improvement. **Third,** clinical, and case management indicators are monitored statewide. Results of PR, QIPs, and HCS/lead agency site visits are reviewed and evaluated for deficiencies and successes. QM committees and stakeholders use this vital information to revise QM tools and improve the quality of HIV services.

A number of HCS QM documents and reports are available online through the HCS Web site at http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/HCS.

There are numerous other QM resources available online to guide quality management and improvement activities, including:

- HRSA's HIV/AIDS Bureau: Quality Management Manual: http://hab.hrsa.gov/tools/QM
- National Quality Center for HIV/AIDS Care: http://www.NationalQualityCenter.org
- HIV Clinical Resource- New York State Department of Health AIDS Institute : http://www.hivqual.org

The overall QM activities reflect a continuous process, which improves and informs the delivery system of outcome results, and demonstrates a commitment to quality services for all individuals served within the RWB provider network. VDH, in collaboration with QM Committees, uses quality results to evaluate clinical and service data, identify gaps and barriers to attaining performance, communicate data analysis findings to stakeholders, and monitor the effectiveness of interventions.

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Richmond, Virginia 23219-2448
Phone # (804) 864-7228
Fax # (804) 864-7629
ATTN: **Krystal M. Hilton, Quality Management Coordinator**
Email: Krystal.Hilton@vdh.virginia.gov

RYAN WHITE PART B DATA MANAGEMENT SERVICES

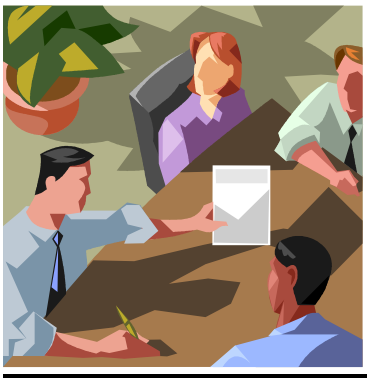
Part B of Ryan White HIV/AIDS Treatment Extension Act 2009 requires that data be collected and reported to HRSA on a quarterly and annual basis for all funded programs. The Survey and Evaluation Research Laboratory (SERL) at Virginia Commonwealth University (VCU) developed and maintains a customized, web-based application, VACRS, to collect and report client-level service data for care programs. SERL has been providing data management services for Virginia's HCS data since the initiation of the program. VDH has developed a database for tracking ADAP client-level data and maintains that database and provides updated reports to local health departments on active clients.

HCS also has its own data management and analysis group that includes a services analyst who analyzes and interprets statistical data related to HIV service delivery, and health services-related epidemiological trends associated with Ryan White programs (e.g., medications, treatment, transportation and mental health services) to evaluate program performance and forecast future needs. Also, within the data group are an ADAP data manager who manages the monthly prescription data for ADAP as well as the data for the ADAP waitlist, a health planner who collects data for the statewide coordinated statement of need (SCSN) and the Ryan White Comprehensive Plan, a database programmer, a data manager for the Special Projects of National Significance (SPNS) Systems Linkages grant, who manages the data collection and evaluation for that four year grant, and two data entry positions, who enter ADAP applications and re-certifications.

Virginia Commonwealth University (VCU),
Survey and Evaluation Research Laboratory (SERL)
Street Address: 912 West Grace Street,
Richmond, Virginia 23284
Phone: (804) 828-0779, Fax: (804) 827-3793
Toll Free Technical Assistance Line: 1-866-578-5672
ATTN: **Kim Hunter, Research Specialist Senior**
Email: khunter@vcu.edu

HCS Services Analyst, Anne Rhodes, (804) 864-8013, Anne.Rhodes@vdh.virginia.gov
HCS Health Planner, Hunter Robertson, (804) 864-7412, Hunter.Robertson@vdh.virginia.gov
HCS ADAP Data Manager, Rishelle Anthony, (804) 864-8013, Richelle.Anthony@vdh.virginia.gov

RYAN WHITE PART B CONSORTIA



A Consortium is generally an association of public, nonprofit private health care and support services providers, community-based organizations, community individuals, and individuals infected and affected by HIV/AIDS. The Consortium analyzes gaps in medical and support services in its area and develops a comprehensive plan to address these gaps.

The Lead Agency for the Consortium conducts or updates an assessment of HIV/AIDS service needs for their geographical area, establishes a service delivery plan based upon prioritized services, coordinates and integrates the delivery of HIV-related services, assures the provision of comprehensive outpatient health and support services, evaluates its success in responding to service needs, and measures cost-effectiveness of mechanisms used to deliver comprehensive care.

The Northern Virginia HIV Care Consortium, the Northwest HIV Care Consortium, and the Southwest/Piedmont HIV Care Consortium (SWVHCC) are the three consortiums currently operating in the Commonwealth. On January 1, 2014, the Institute for Innovation in Health and Human Services at James Madison University will no longer be the VDH lead fiscal agent for the Northwest Region HIV Care Consortium. VDH will directly contract with HIV service providers in this region. No disruption of services is expected during this transition period.

VDH directly contracts with HIV service providers in the Eastern and Central regions.

For your convenience, points of contact for each of the three lead agencies are provided below.

VIRGINIA HIV CARE CONSORTIA

Northern Virginia HIV Care Consortium (NVHCC)

Northern Virginia Regional Commission (NVRC)
Street Address: 3060 Williams Drive, Suite 510
Fairfax, Virginia 22031
Phone # (703) 642-0700
Fax # (703) 642-5077
ATTN: **Michelle Simmons, Program Director**
Email: msimmons@novaregion.org

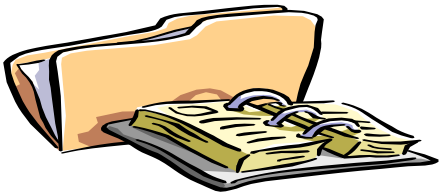
Northwest HIV Care Consortium (NWVHCC)

Institute for Innovation in Health and Human Services
James Madison University
Street Address: 601 University Boulevard, MSC 9009
Harrisonburg, Virginia 22807
Phone # (540) 568-3178
Fax # (540) 568-6374
ATTN: **Gary Race, Program Director**
Email: racegs@jmu.edu
Jane Hubbell, Associate Director, IIHHS, JMU
Email: hubbeljx@jmu.edu

Southwest/Piedmont HIV Care Consortium (SWVHCC)

Council of Community Services (CCS)
PO Box 598, Roanoke, Virginia 24004
Street Address: 502 Campbell Avenue SW
Roanoke, Virginia 24004
Phone # (540) 985-0131
Fax # (540) 982-2935
ATTN: **Robert Morrow, Program Director**
Email: robertm@councilofcommunityservices.org

WHAT TO EXPECT FROM YOUR VDH HIV SERVICES COORDINATOR



Your HIV Services Coordinator is your first point of contact with the DDP regarding any contractual matters. You can expect the following from your HIV Services Coordinator:

1. He or she will address your questions or concerns within a timely manner. The HIV Services Coordinator will seek assistance from other Division staff when appropriate.

2. Once a new contract/memorandum of agreement (MOA) is signed, you will be provided with the following forms from your HIV Services Coordinator (as applicable): "Request for Payment" and "Budget Reallocation Request" forms.

3. Review of your monthly or quarterly progress reports with written feedback will be provided within 15 days after the receipt of the reports into the VDH office. Follow-up with further information/explanation may be requested.

4. Your HIV Services Coordinator will conduct at least one site visit per year. This visit will be programmatic, administrative, and fiscal. During this visit, your HIV Services Coordinator may request to review program policies and procedures, time and effort sheets, fiscal invoices and any other documentation relating to the operation of your contract/MOA. Written feedback of the site visit will be prepared within 30 days. Site visits are designed to comply with the new HRSA Monitoring Standards which became effective during the FY 2011 grant year. For more information on the new monitoring standards please go to: http://hab.hrsa.gov/manageyourgrant/granteebasics.html

5. Your HIV Services Coordinator will provide technical assistance as appropriate and will notify you when work plan revisions and budget reallocations have been approved by the Division. (See more information under the Work Plan and Budget Reallocation Section.)

6. If the contract/MOA is to be renewed, your HIV Services Coordinator will notify you of the intent to renew approximately 90 days prior to the end of your current contract. The letter will indicate the contractual period and the amount to be awarded, as well as indicate when the contractor's work plan is due to the Division.

WHAT VDH EXPECTS FROM ITS CONTRACTORS

Direct Service Providers and Subcontractors:
The VDH DDP initiates direct agreements for some services instead of contracting through Consortia. Direct Service Providers are those entities that have direct agreements (MOA or contract) with VDH. Under the reauthorized Ryan White Treatment Extension Act of 2009, at least 75% of the service dollars must be used to provide core medical services as described under Ryan White legislation. All statewide services, including core medical services, delivered through Consortia are deemed support services (PHS Act Sec. 2614(a)[1-3]).

For the purposes of this manual, "subcontractors" are those entities that have agreements with entities that contract directly with VDH. Contractors are responsible for ensuring that subcontractors comply with all terms of funding, including federal and state polices and legislation.

Contractor and Subcontractor Responsibilities:

- Delivery of quality services to HIV/AIDS eligible clients.
- Ensure client eligibility.
- Submit monthly or quarterly reports in a timely manner.
- Comply with all components of the contract between VDH and the agency or the Consortium and the agency.
- Implement and maintain an invoice system using standard accounting practices; that when tallying receipts to request reimbursement on the invoice no rounding is allowed. VDH will reimburse the exact amount specified on the supporting documentation supplied with request. Client identifying data should be removed from all documents supplied with the invoice prior to submitting to VDH.
- Report program income receipts, expenditures, and balances.
- Establish, implement and evaluate a continuous quality improvement system.
- Participate with the Peer Review process (described earlier in this document).
- Ensure that all clients who receive services use any and all available third party payer funds prior to using Ryan White funds; Ensures that RWB-funded copayment assistance provided by the contractor (or subcontractors) for antiretroviral medications (ARVs) occurs only after all alternative methods of payment, including Copayment Patient Assistance Programs (Copay PAPs), have been attempted.
- Collect and maintain back-up documentation for all invoices submitted to the fiscal agent for payment.
- Ensure confidentiality of all client records.
- Maintain current policies and procedures manuals.

- Prepare and follow an annual work plan and budget approved by VDH or the Lead Agency.
- Comply with federal and state policies and legislation associated with funding.
- Maintain client level information in an approved database.

Quality Management Contractor Requirements:

Effective April 1, 2013, contractors are expected to do the following as part of their agreement with VDH:

A. Contractor shall develop/update and submit an annual Ryan White (RW) quality management plan, inclusive of all funded program components, activities and protocols to be used in measuring and monitoring service delivery, program successes, and effectiveness of the funded services on the health outcomes of persons living with HIV/AIDS (PLWHA). The plan must include a description of the agency's (RW) quality management infrastructure; include roles and responsibilities of staff overseeing quality management, frequency of quality meetings, supporting documents, dedicated resources, and a description of how consumers are involved in quality-related activities.
B. Contractor shall complete a minimum of one (1) program-specific quality improvement (QI) initiative per year based on identified need of client population and/or service delivery process challenge. Progress of QI initiative will be reported on a quarterly basis.
C. Contractor shall participate in statewide quality management activities (meetings, trainings, improvement projects and data/report submission requests), to include four (4) meetings at a minimum, the annual QM Summit and quarterly quality meetings (see chart below for dates).
D. Contractor shall include updates on quality management plan implementation and monitoring each month through the submitted monthly progress reports.

FY 2013 Contractor Timeline for Quality Management Activity Deliverables

Quality Area	Quality Activity	Responsible Person	Timeline
Quality Improvement (QI) Project	**Ryan White Provider (RWP) Quality Improvement Project Development Technical Assistance *(by request)***	**QM Coordinator**	**As needed through June 14, 2013**
	RWP QI Project Proposal	Contractors	June 28, 2013
	RWP QI Project Feedback	QM Coordinator	July 31, 2013
	QI Project Report (RWP)	Contractors	September 30, 2013 December 20, 2013 March 31, 2014
	QI Project Implementation, Monitoring & Feedback *(Statewide)*	Contractors QIPT QMAC QM Coordinator	Ongoing

Quality Area	Quality Activity	Responsible Person	Timeline
Quality Management (QM) Plan	QM Plan Development Technical Assistance *(by request)*	QM Coordinator	As needed through August 16, 2013
	QM Plan	Contractors	August 30, 2013
	QM Plan Feedback	QM Coordinator	September 30, 2013
	QM Plan Monitoring *(Statewide)*	QMAC QM Coordinator	Ongoing
Quality Monitoring	Performance Measures (PM) Monitoring *(via Monthly Report)* & Feedback *(via Monthly Report Response)*	Contractors HIV Service Coordinators QM Coordinator	Monthly
	QM Plan Monitoring *(via Monthly Report)* & Feedback *(via Monthly Report Response)*	Contractors HIV Service Coordinators QM Coordinator	Monthly (Oct. – March)
Direction	Quality Management Advisory Committee (QMAC) Meeting	QMAC Members	May 7, 2013 August 13, 2013 February 11, 2014
Information Sharing	QM Newsletter	QM Coordinator	July 31, 2013 October 31, 2013 January 31, 2014 April 30, 2014
Training	QM Summit	QM Summit Planning Committee QMAC AETC/VHARCC QM Coordinator	November 12, 2013
	Training and Technical Assistance	QM Coordinator AETC/VHARCC	Ongoing

For questions about the quality management requirements, please contact your contract monitor or Ms. Krystal Hilton at krystal.hilton@vdh.virginia.gov or (804) 864-7228.

Below is some further information that is specific to Ryan White Program funding.

Eligible Clients:

Eligible clients are individuals and families who are infected and/or affected by HIV disease and meet program income eligibility requirements. Proof of HIV diagnosis is required, with appropriate documentation of proof further defined in the "Policy on HIV Diagnosis Documentation" developed by HCS and that follows HRSA and Centers for Disease Control and Prevention (CDC) 2013 diagnosis of HIV disease guidance. This policy may be obtained through HIV Services Coordinators (Contract Monitor) if needed. Eligibility requirements are updated at least every six months and may be accessed on the Web at: http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/HCS/.

Clients who have access to private insurance coverage through an employer or family member should utilize this option before relying on Ryan White funding, as Ryan White funding is considered a payor of last resort. Some ADAP clients have been enrolled in the federal government's Pre-existing Condition Insurance Plan (PCIP) in 2013, and beginning on October

1, 2013, eligible ADAP clients will be assisted with enrollment into a federal health insurance exchange that will provide insurance coverage starting January 1, 2014.

Ryan White Co-payments:

Specific to Ryan White legislation, co-payments for services are subject to certain conditions. Services provided under RWB funding must follow these conditions. A summary of the co-payment terms follows:

- In the case of individuals with an income less than or equal to 100 percent of the official poverty level (FPL), the provider will not impose co-pay charges on any individual for the provision of services;

- In the case of individuals with an income greater than 100 percent of the FPL, the provider will impose co-pay charges on each individual for the provision of such services and will impose charges according to a schedule of charges that is made available to the public;

- In the case of individuals with an income greater than 100 percent of the FPL and not exceeding 200 percent of the FPL, the provider will not, for any calendar year, impose charges in an amount exceeding 5 percent of the annual gross income of the individual involved;

- In the case of individuals with an income greater than 200 percent of the FPL and not exceeding 300 percent of the FPL, the provider will not, for any calendar year, impose charges in an amount exceeding 7 percent of the annual gross income of the individual involved, and;

- In the case of individuals with an income greater than 300 percent of the FPL, the provider will not, for any calendar year, impose charges in an amount exceeding 10 percent of the annual gross income of the individual involved.

Monthly or Quarterly Progress Reports/Evaluations:

Monthly or quarterly reports are due by the 30th of the month following the end of the month or quarter. Contractors are offered the option of submitting electronically at the HIV Services Coordinator's discretion. The HIV Services Coordinator would then be responsible for printing a hard copy to maintain on file (hard copies are an audit requirement). If mailed, reports should be sent to the DDP Director, Virginia Department of Health, Division of Disease Prevention, 109 Governor Street, P.O. Box 2448, Room 326, Richmond, VA 23218-2448 or hand delivered. See the attachment, Instructions for Completing Contractor Report Narratives, A—6, for additional information.

A. REIMBURSEMENT FOR CONTRACTUAL EXPENDITURES

Monthly or quarterly payments will be reimbursed within 30 days of receipt, unless VDH disputes some aspect of the invoice. If the invoice is disputed, the reimbursement will occur 30 days after the dispute is resolved. Your HIV Services Coordinator will review the requests for payment for accuracy and will forward to the fiscal office within 7 days, unless there is a discrepancy.

Monthly or quarterly requests for payment are due by the 30th of the following month or quarter. Please refer to the Division Contract Budget Line Item Format when submitting requests for payments. A copy is located in the Attachments Section, Attachment #A-2. The time frame should correspond to the funding time period of your contract. These categories are provided to ensure appropriate ordering of budget categories and placement of line items. This document also describes what each line item entails. The invoice should reflect the line items in the approved budget.

Each Contractor must develop a budget that will enable it to comply with uniform administrative requirements to compare actual expenditures or outlays with budgeted amounts for each grant or sub-grant. Each contractor must develop a budget for each grant that it receives. The developed budget will be part of the grant application or competitive procurement process or as part of a grant renewal process. Contractors must develop budgets based on the allocations they receive from VDH. VDH recommends that each contractor include the following procedures for budget development:

- Identify expected allocations by contract, category and year of appropriation;
- Identify expenditures by functional classification and cost category;
- Develop written budget justifications and processes that specify the process by which the budget is developed, approved, implemented, monitored and revised; and
- Submit and maintain supporting documentation for budgeted amounts.

If VDH receives a request for payment for the current month or quarter, prior to the last day of that month or quarter, VDH will not process the request until the following month or quarter. Example: if the contractor requests payment for the month of December and the request for payment is received any day during the month, it will not be processed until the beginning of January.

All awarded monies must be obligated or spent by the last day of the grant year. Unexpended funds may not be carried over to the next funding year. However, contracts can be extended as long as the extension is still within the same grant period. In January VDH will start the process of de-obligating funds from contractors that will not spend all of their funds during the grant year. Contractors who do not feel that they will expend all funds by the end of the grant year should contact their HIV Services Coordinator to voluntarily de-obligate funds before they are contacted by VDH.

"Funds obligated" means there is written documentation between you and a vendor/provider for the service or products; however, the contractor has not yet received the actual bill or invoice.

The contractor shall be paid on the basis of invoices submitted, completion of objectives, and submission of required reports. VDH may elect to withhold payment if contractual obligations are not met.

Please put the grant program name, FIN/EIN number and ***full*** contract number on request for payments so that they will be routed to the correct HIV Services Coordinator. Use of agency given names for grant programs can delay processing. Invoices and requests for payment must be mailed. FAXED INVOICES will NOT be accepted. Occasionally the contractor may need to send in an invoice faster than through the mail. In those circumstances, at the discretion of the HIV Services Coordinator, invoices may be sent through email in a PDF format or scanned into a jpeg file.

VDH Invoice Submission Guidelines:
See the section, Financial Management of Your Grant, for this information.

B. WORK PLAN AND BUDGET REALLOCATION REQUEST

Work Plan Revision:
Contractors should send a letter or email of request indicating the proposed changes to their work plan to their HIV Services Coordinator who will route it through VDH for approval. The letter of request should be addressed to the Division of Disease Prevention Director, Diana Jordan, Virginia Department of Health, Division of Disease Prevention, P.O. Box 2448, Room 326, Richmond, VA 23218. VDH must approve all proposed changes prior to the contractor implementing these changes. Your HIV Services Coordinator will provide written notification to you once approval is granted. At this time, you will need to provide a complete revised work plan to your HIV Services Coordinator.

Budget Reallocation:
A completed budget reallocation form must be submitted to your HIV Services Coordinator who will route it through VDH for approval. The contractor must supply all information requested on the form. Budget reallocations must be submitted **no later than 30 days prior** to the end of the contractual year, unless approved by your HIV Services Coordinator. Contact your HIV Services Coordinator to discuss exceptional or extenuating circumstances. Budget reallocations may be submitted by fax or by e-mail with an electronic signature.

Please do not assume that submission of a budget reallocation request means automatic approval. New expenditures should not be made until the reallocation is approved; therefore, the budget should not be changed on the request for payment form until approved by the Division. Once the

signature of the Program Manager or designated appointee has been obtained, a copy of the approved budget reallocation request form will be forwarded to the contractor. The budget reallocation form is available on the VDH/DDP website at the following address:

http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/ddp_customer_forms.htm

A copy is located in the Attachments Section, Attachment #A-3.

Carry-over Funds:
Funds **cannot** be carried over to the following year. If you anticipate being unable to spend all funds by the end of the budget year, notify your lead agency or HIV Services Coordinator as soon as possible but no later than **60 days prior** to the end of the budget year.

C. OTHER CONTRACT INFORMATION

Contract Modifications:
A contract modification occurs when there is a change in the scope of service or award amounts within the contract period. Contractors are required to submit a revised work plan, budget, and budget justification whenever a contract modification is requested. As part of the contract modification or renewal package, contractors are also asked to provide an allocations table that includes service cost, number of clients, number of units, cost per unit and client. If the cost per unit and/or client is high, give a cost explanation. See the Allocations Table Template in the Attachments section, Attachment # A-5 as an example.

Contract Renewals:
Many contracts/MOAs allow for multiple renewals, depending on funding availability and other program factors. Contracts/MOAs are renewed at the discretion of VDH, generally based on performance.

The contractor is responsible for submitting a work plan, budget, budget justification, and allocations table for the new contractual period. The work plan should include process and outcome objectives. Action steps/activities should be included under each process objective. Once all steps have been completed for the renewal process, an original signed contract will be forwarded to the contractor.

All contractors are now required to submit their workplans containing HRSA service categories, number of clients, number of service units and the service unit definitions.

Start-up Funds for New Contracts Only:
Start-up funds are generally available for new agreements only. Start-up funds should be requested at the time of contract negotiations.

Once contracts/MOAs have been signed by the DDP and VDH administration, the DDP will process start-up fund requests. Letters requesting start-up funds should be submitted along with the budget and work plan to the DDP Director.

Program Income:
Sub-grantees (contractors) are required to meet the standards and requirements related to program income referenced in the Code of Federal Regulations, 45 CFR 92.25, found at http://cfr.vlex.com/vid/92-25-program-income-19932128. Program income is any income generated by or earned as a result of the grant. This includes charges to beneficiaries under the sliding scale, as well as reimbursement from Medicaid, Medicare, private insurance or third-party payors for services provided. Sub-grantees (contractors) must have a system in place to track and monitor grant specific receipt and expenditure of program income. Contractors are required to report all sources of service reimbursement as program income to VDH.

Program income should be budgeted as a resource with specific plans for expenditure, recorded in the accounting system and designated as Ryan White for both receipt and expenditure. Acceptable tracking systems show program income amounts collected and expended as well as amounts apportioned by program either in the accounting system or summarized on a spreadsheet. All program income earned must be used to further objectives of the HIV program.

Audits:
Agencies that receive more than $100,000 in federal funding must submit a signed "Certification Regarding lobbying" form and, as appropriate, a "Disclosure of Lobbying Activities" to account for non-appropriated funds used for this purpose to the VDH within 90 days of the start of the funding period. Contractors are responsible to ensure they collect and submit this documentation for any subcontractors that receive more than $100,000 in federal funding to VDH within the same time frame. (Regulations and forms can be obtained at http://ecfr.gpoaccess.gov.)

Contractors that receive more than $500,000 per year in federal funding from all sources are required to have an A-133 audit conducted annually. The A-133 audits must include statements of conformance with federal financial requirements. A copy of the A-133 audit or the single audit and the Auditor management letter shall be submitted to VDH annually.

Assurances:
All contractors and subcontractors will certify annually with signed assurances that Ryan White funds are not used for unallowable expenses. A copy of the Assurances Statement is located in the Attachments Section, Attachment #A-14.

Contractor Quarterly Meetings:
Contractors are required to attend quarterly statewide Contractors' Meetings. Your HIV Services Coordinator will discuss this requirement with you. Updated contractual information and Division policies may be shared during these meetings. Technical assistance and/or capacity building/educational trainings are included in these meetings. Contractors are expected to arrive on time, sign in and **remain for the duration of the meeting** unless other arrangements have been made with your HIV Services Coordinator ***prior*** to the meeting date.

Material Review:

All educational materials supported with VDH funds must be approved by the **VDH Materials Review Panel**. Prior to release contractors will be responsible for any of the materials used by subcontractors. Educational materials include brochures, flyers, posters, video and audio tapes, questionnaires, surveys, curricula or outlines for educational sessions, public service announcements, web pages, etc. This approval is required **prior** to purchasing and/or distribution.

To submit materials to the panel for approval, please contact your HIV Services Coordinator. Items should be submitted electronically for fastest response. If mailed, seven copies of documents are required for any items submitted on paper. The review process may take 10 to 30 days, so please plan accordingly. It is helpful to describe the setting and audience for the materials. If materials are not approved by the review panel, contractors must not use grant funds to purchase or pay for the cost of developing, printing and/or distribution of the unapproved materials.

Data Security and Confidentiality Guidelines:

Contractors are required to comply with the VDH, DDP Data Security and Confidentiality Guidelines. The DDP's Security and Confidentiality Guidelines (hereafter referred to as the Confidentiality Guidelines) is intended to ensure privacy, confidentiality, and security principles of the Division's patient level information, in accordance with Commonwealth of Virginia laws and regulations, as well as the Centers for Disease Control and Prevention (CDC) HIV/AIDS security guidelines related to HIV/AIDS.

This document serves as a reference to guidelines that ensure the confidentiality and security of information and data collected by and for the Division's programs. The guidelines also assist with the Division's compliance with relevant state and federal laws and regulations concerning the protection of confidential information.

Guidelines will be made available to all contractors on an annual basis. Contractors are asked to sign a Certificate of Receipt that does not imply agreement or disagreement with the guidelines; however, all contractors are required to comply with the Guidelines. A copy of the Certificate of Receipt form is located in the Attachments Section, Attachment #A-15.

Continuity of Operations Plan (COOP)

Each contractor, lead agency and subcontractor is required to prepare a Continuity of Operations Plan (COOP) to ensure continued access to essential services and care for all clients, including their Ryan White and State funded clients, in case normal operations cannot continue (in case of a disaster or emergency). This plan should be reviewed and updated annually. See the Attachments Section, Attachment #A-9, for a list of resources for developing a COOP.

Guidance for developing a COOP:

1. Perform a risk assessment to evaluate systems or processes that might be vulnerable in an emergency situation. Determine what kinds of hazards pose the greatest risks for your agency/area. Identify "mission critical functions" and resources that are necessary to deliver services to clients. Dissect the steps and procedures necessary to perform these functions. Evaluate which systems and/or processes might be affected by an emergency or disaster. Consider and develop alternative or supplemental methods of performing these duties/tasks should normal service delivery mechanisms be interrupted.

2. Identify staff necessary to perform "mission critical functions." Create a personnel roster and identify key individuals associated with completing the essential functions as well as backup personnel who could complete those tasks. Establish an identified chain of command of appropriate staff with pre-assigned duties and authority.

3. Develop and implement a system to protect records, assets, data, equipment, and facilities; include a plan for data backup and storage on and off-site in a secure location(s).

4. Create a key personnel emergency call list. Update the list at least annually. Develop an internal and external communication plan to notify staff, clients, funders and external agencies and stakeholders about the status of services and programs. List the external agencies (federal, state, local, satellite offices, etc.) who must be notified when your work unit is unable to perform functions as usual.

5. Identify worksites (offsite or remote locations) to serve as alternative operations centers until services and programs can return to the original worksite. Develop relationships, agreements, and mechanisms with key organizations, stakeholders, and partnering agencies in order to ensure uninterrupted delivery of/access to services and care to clients.

6. Create an equipment and resource list that would be required for the essential personnel to function. Prepare a "to go" kit to maintain a mini operations center.

7. Assist staff and clients with creating their personal/family emergency needs plans. Disseminate disaster preparedness information to staff and clients. Encourage them to develop an emergency preparedness plan. Maintain a file of staff emergency preparedness plans and contact information in a secure location on and off site.

WHAT TO EXPECT FROM CLIENTS

The client has the right to:

- Be treated with respect, compassion and sensitivity.
- Receive services and benefits without discrimination of any kind.
- Have all aspects of care and services treated with privacy and confidentiality.
- Have service providers' confidentiality policy explained.
- Make informed choices about what information is released and to whom.
- Be fully informed about all services available through the agency.
- Have agency grievance procedures explained.
- Have complaints responded to in a timely manner without risk of detrimental effect on client's services.
- Refuse care and /or discontinue services at any time.

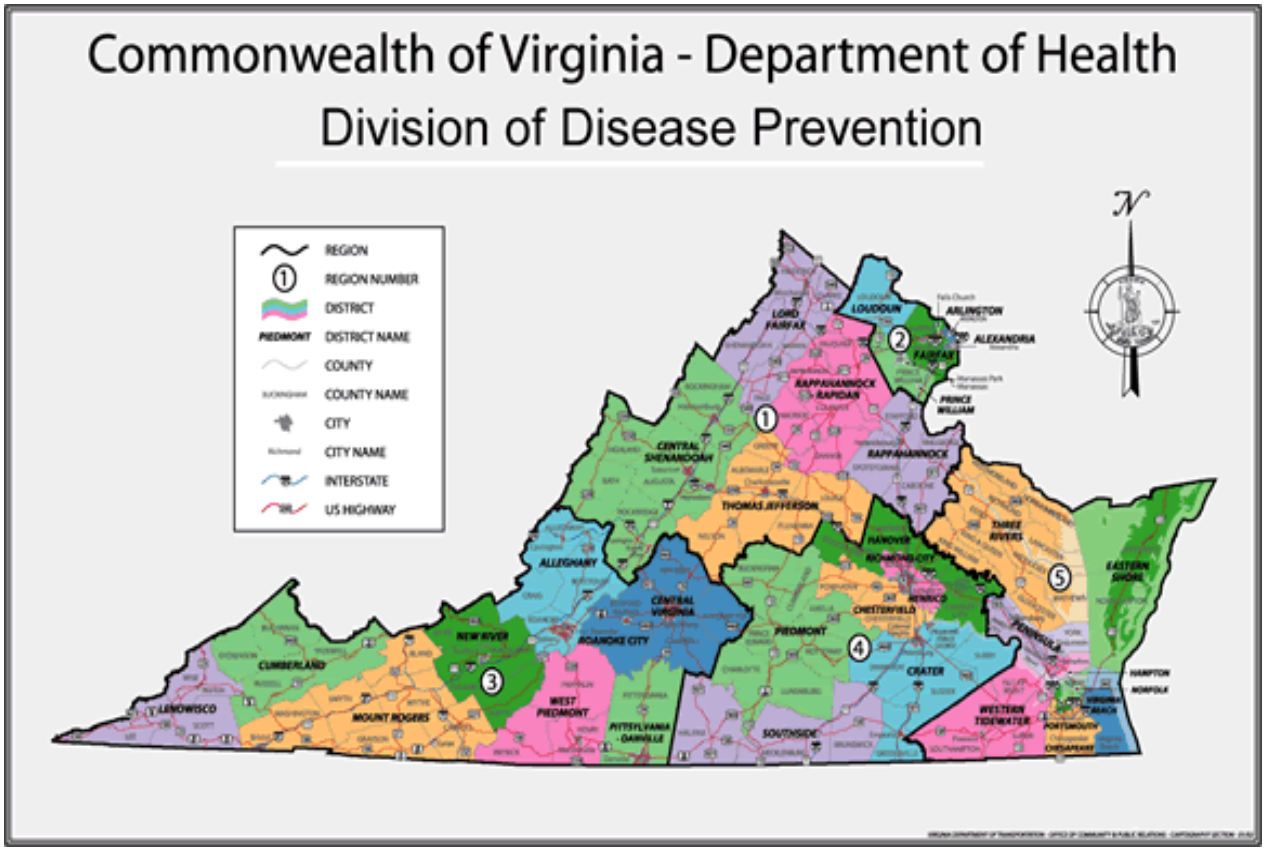
The client has the responsibility to:

- Treat agency staff and volunteers with respect and refrain from abusive language and behavior in communication or when communicating with them.
- Be an active participant in obtaining services and maintaining his/her personal well being.
- Notify service providers of any changes to address, phone number, and health, financial or living situation.
- Apply for all eligible benefits in 30 days.
- Keep appointments or cancel in advance.
- Respect the confidentiality of others.
- Provide adequate and accurate information to insure appropriate services are rendered.
- Provide feedback about the effectiveness of services rendered.
- Bring any complaint or grievance to the attention of the service provider.
- Allow your chart to be reviewed by the administrative agent to ensure that services are being provided and bills are being paid according to the standards set by service providers.

FISCAL MANAGEMENT OF YOUR GRANT

The section, "Fiscal Management of Your Grant" is under revision. These guidelines will be updated when revisions are complete. Please contact either the HCS Business Manager or an HIV Services Coordinator with any questions.

ATTACHMENTS



Regions and Consortia

Region 1: **Northwest HIV Care Consortium**
Region 2: **Northern Virginia HIV Care Consortium**
Region 3: **Southwest/Piedmont HIV Care Consortium**

Virginia Department of Health
Division of Disease Prevention
Budget Line Item Format

The following categories and format are being provided to ensure appropriate ordering of budget categories and placement of line items. The descriptions under each are examples of allowable costs but may not be approved or included in every contract. Specific line items and costs are negotiated in your initial contract with any modifications requiring approval. If you have any questions, please contact your HIV Services Coordinator.

Caps on Expenses:
All Part B contractors can allocate up to 10% of their grant award for administration, planning and evaluation. In accordance with the new HRSA Monitoring Standards, this now includes rent and utilities for medical facilities which in the past, used to be included in Direct Services. Contractors may choose to pass on a portion of the 10% to their subcontractors, but combined administration, planning and evaluation for contractors and their subcontractors cannot exceed 10 percent. VDH allows Consortia and selected contractors to allocate up to 5% of the total grant award for CQM if approved by VDH.

Include the following in the Budget Justification narrative:

Personnel Costs:
Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percent of full time equivalency charged to RW Part B and annual salary. Other funding streams supporting remaining salary costs and the corresponding full time equivalency must also be identified.

Indirect Costs:
Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For institutions subject to OMB Circular A-21, the term "facilities and administration" is used to denote indirect costs. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may wish to obtain one through HHS's Division of Cost Allocation (DCA). Visit DCA's website at: http://rates.psc.gov/ to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them. If you do not have documentation from a federal agency of your indirect rate negotiated in accordance set forth in the federal circular 2 CPR 220, you may not invoice for indirect costs. Instead you must budget your administrative costs by line item

Fringe Benefits:
List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project.

Travel:
List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops. Travel for staff business must be made in the most cost effective way possible. Taxi fare for staff travel will not be reimbursed except for some situations concerning out of town travel (such as travel from an airport to a hotel). Justification for use of taxi's out of town must be submitted with your invoice.

Equipment:
List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification of the need for the equipment and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of $5000 and a useful life of one or more years). Extensive Justification will be defined in the Invoice Submission Guidelines issued under separate cover.

Supplies:
List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, paper towels, toilet paper and the like; medical supplies are syringes, blood tubes, plastic gloves, etc., and educational supplies may be pamphlets and educational videotapes. They must be listed separately.

Subcontracts:
To the extent possible, all subcontract budgets and justifications should be standardized, and contract budgets should be presented by using the same object class categories contained in the Standard Form 424A. Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables.

Other:
Put all costs that do not fit into any other category into this category and provide and explanation of each cost in this category. In some cases, grantee rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate.

Start-up:
Start-up funds are available for new contracts only. This does not include renewals. Start up funds should be requested at the time of contract negotiations. Once contracts have been signed by the DDP and VDH administration, the DDP will process start-up fund requests. Start-up funds may not exceed 1/12 of the total budget. Letters requesting start-up funds should be submitted along with the budget and work plan to the Division Director.

PROGRAM: _____
AGENCY: _____
CONTRACT/MOA #:_____
GRANT YEAR (specify start and end dates) _____

	Direct Service	Administrative	Quality Management (If Allowable)	Planning and Evaluation (If Allowable)	**TOTAL**
1. Personnel					
2. Fringe					
3. Travel					
4. Equipment					
5. Supplies					
6. Contractual					
7. Other					
8. Indirect					
9. Start Up					
TOTALS					

Signature: _____ Date: _____

Definitions:

Direct Service – Activities related to direct client service (i.e. personnel that work with clients and/or determine eligibility and those that directly supervise service provision)

Administrative– Activities related to operation of the agency, but not directly involved in client services (i.e. accountant, rent, agency operations, and administrative staff).

Planning and Evaluation (if allowable) - Activities related to needs assessments, client satisfaction, evaluation of effectiveness of system operations, etc.

Quality Management (if allowable) – Activities related to assessing and improving quality of service through meeting and improving outcomes.

Virginia Department of Health (VDH), Office of Epidemiology
BUDGET REALLOCATION
REQUEST

This form is to be used for zero sum budget adjustments only.

ORGANIZATION	
CONTRACT/MOA #	
BUDGET PERIOD	
GRANT PROGRAM	

LINE ITEM	PREVIOUSLY APPROVED BUDGET		REQUESTED BUDGET REVISION
PERSONNEL			
FRINGE			
TRAVEL			
EQUIPMENT			
SUPPLIES			
CONTRACTUAL			
OTHER (SPECIFY)			
INDIRECT			
TOTAL	$ -		$ -

JUSTIFICATION: (Attach new budget justification or additional information, as needed)

1. Reason why funds are available to be re-budgeted.

2. Proposed use for the re-budgeted funds.

CERTIFICATION: I certify that this re-budgeting is necessary to achieve project objectives, is consistent with the contract/MOA terms and conditions and VDH policies, represents effective utilization of resouces, and does not constitute a change in scope.

CONTRACTING AGENCY:

Signature

Printed Name

Title

Date

VDH APPROVAL:

Contract Monitor Signature

Date

Program Manager Signature

Date

Invoice Template

A-4

Diana Jordan, Director
Division of Disease Prevention
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Ms. Jordan:

Indicate DDP work unit in the box below:
☐ Field Services
☐ HIV Care Services
☐ HIV Prevention Services
☐ HIV Surveillance
☐ Tuberculosis

Date: _____
Contract #: _____
FIN: _____
Prog Name: _____

In accordance with the contract between the Virginia Department of Health and _____ located at _____. I am requesting payment for services rendered during the time period _____ through _____ in the amount of $ _____. Expenditures by approved budget line items are as follows:

Check here if new address ☐

EXPENDITURES

Line Item	Approved Budget	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Total	Balance
Personnel														-	-
Fringe														-	-
Travel														-	-
Equipment														-	-
Supplies														-	-
Contractual														-	-
Other														-	-
Indirect Cost														-	-
Total	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Program Income Received															
Program Income Expenditures															
Program Income Balance		-	-	-	-	-	-	-	-	-	-	-	-	-	-

I certify that this request for disbursement of funds has been reviewed by me and is accurate to the best of my knowledge and belief. The amounts itemized are considered to be legitimate and proper charges to the grant award indicated and are approved for payment. These charges have not been previously authorized or requested for payment. This certification applies to goods or services received or performed and travel expenses.

Signature **Date**

VDH USE: Use this check list before processing payment invoice

Are the contract number and program name correct ?	
Are the contractor name and FIN correct ?	
Time period falls within contract period ?	
Line item budgets are current (i.e. modifications reflected)?	
Is the total budget amount correct ?	
Does each column add correctly ?	
Have startup funds been shown (if applicable) ?	
Do all prior payments match our records ?	
Does the YTD column match our records ?	
Has the request been signed by appropriate staff person ?	
Monitor made changes, initialed and notified contractor	

Contractor Allocations Table

Contract Period: Name of Program:

Proposed Budget	Cost Per Direct Service Category	Number of Unduplicated Clients	Number of Service Units	Cost per Client	Cost per Unit
A. Direct Service Allocations					
1. Core Medical Services subtotal	$0.00	0.00	0.00	#DIV/0!	#DIV/0!
a. Outpatient /Ambulatory Health Services				#DIV/0!	#DIV/0!
a1. Laboratory Services				#DIV/0!	#DIV/0!
b. AIDS Pharmaceutical Assistance (local)				#DIV/0!	#DIV/0!
c. Oral Health Care				#DIV/0!	#DIV/0!
d. Health Insurance Premium & Cost Sharing Assistance				#DIV/0!	#DIV/0!
e. Mental Health Services				#DIV/0!	#DIV/0!
f. Medical Case Management (including Treatment Adherence)				#DIV/0!	#DIV/0!
2. Support Services subtotal	$0.00	0.00	0.00	#DIV/0!	#DIV/0!
a. Case Management (non-Medical)				#DIV/0!	#DIV/0!
b. Child Care Services				#DIV/0!	#DIV/0!
c. Food bank/home delivered meals				#DIV/0!	#DIV/0!
d. Health Education / Risk Reduction				#DIV/0!	#DIV/0!
e. Legal Services				#DIV/0!	#DIV/0!
f. Medical Transportation Services				#DIV/0!	#DIV/0!
g. Early Intervention Services				#DIV/0!	#DIV/0!
h. Psychosocial Support Services				#DIV/0!	#DIV/0!
i. General support to ADAP for medication access				#DIV/0!	#DIV/0!
j. ADAP eligibility and Medicare Part D Assistance				#DIV/0!	#DIV/0!
k. Treatment Adherence				#DIV/0!	#DIV/0!
l. Referral for health care/supportive services				#DIV/0!	#DIV/0!
m.Planning/Eval				#DIV/0!	#DIV/0!
3. Subtotal Direct Services, Clients, and Units	$0.00	0.00	0.00	#DIV/0!	#DIV/0!
4. Admin	$0.00	%Admin	#DIV/0!		
5. QM	$0.00	%QM	#DIV/0!		
6. TOTAL DIRECT SERVICES BUDGET WITH ADMIN AND QM	**$0.00**	**0**	**0**		

B. Budget Line Item Allocations	Direct Services	Admin	QM
1. Personnel			
2. Fringe			
3. Travel			
4. Equipment			
5. Supplies			
6. Contractual			
7. Other			
8. Indirect			
9. Start Up			
10. Budget Allocation Subtotals	$0.00	$0.00	$0.00
11. TOTAL BUDGET LINE ITEM ALLOCATIONS	$0.00		
Comments:			

Helpful Hints on How to Use the Contractor Allocations Table

Section A: Direct Service Allocations

1. Core Services
   - Cost Per Direct Service Category: put in the total requested funds per service category
   - Number of Unduplicated Clients: put in the number of projected unduplicated clients to be served in each service category
   - Number of Service Units: put in the number of service units to be provided in each service category
   - Cost Per Client: divide the total cost of service by number of clients to be served (formula should do this for you)
   - Cost Per Unit: divide the total cost of service by number of units to be provided (formula should do this for you)

2. Support Services
   - Complete the above steps for A-M support services

3. Subtotal Direct Services, Clients, and Units

- Add the total core and support services costs to get the subtotal for direct services (formula should do this for you)
- Add the total core and support projected number of unduplicated clients to be served and the number of projected service units to be provided (formula should do this for you)
- Determine the cost per client and unit by dividing each category by the total amount of direct services (formula should do this for you)

4. Administration (Admin)

- Once you've completed the budget line item allocations section (section B), the total administrative cost and percentage should appear. If this does not happen, take the total Admin cost (from Admin Budget Allocation Subtotal, cell C70) and divide by total direct services cost to get the percentage. Keep in mind that 10% or under is the allowable rate for administration costs.

5. Quality Management (QM)

- If you are funded for QM and once you've completed the budget allocations section (section B), the total QM cost and percentage should appear. If this does not happen, take the total QM cost (from QM Budget Line Item Allocation Subtotal, cell D70) and divide by total direct services cost to get the percentage. Keep in mind that 5% or under is the allowable rate for QM costs.

6. Total Direct Services Budget with Admin and QM costs

- Add total direct services, Admin, and QM costs (B28+B29+B30). The total should match the Total Budget Line Item Allocations total (cell B70).

Section B: Budget Allocations

1-9. Include how much of the requested funds is Direct, Admin, or QM for each line item (personnel, fringe, etc.)

10. Subtotals for Direct, Admin and QM should appear automatically.

11. The Total Budget Line Item Allocations is the sum of the direct, admin, and QM subtotal amounts. This number should match the Direct Services Budget with Admin and QM total (cell B31). The formula should do this for you.

INSTRUCTIONS FOR COMPLETING CONTRACTOR REPORT NARRATIVES

Description:
Program reports are an instrument for contractors to update the VDH, HCS Unit on the progress of the activities being carried out according to the agreement with VDH for the provision of Ryan White Core and Support Services. The report should reflect accurate and complete information about the progress to goals outlined in the work plan of each contractor. The instructions below will provide a clear explanation for each section of the document.

Program Report Section Instructions:
Below is a detailed explanation for each section of the program report document. Please review all information carefully to ensure the correct information is being recorded.

Highlights:
In this section, it is expected that contractors will highlight/ summarize activities being carried out as part of RWB services. Report any activities that impact the program. These impacts can be either positive or negative in nature. An example is: *Contractor X conducted a workshop for clients on the importance of stress management to reduce illness.*

Restatement of Objectives:
In this section, contractors should import their process objectives that are started in the approved work plan. It is **NOT** necessary to import outcome objectives or activities in this section. Below are examples of process objectives, outcome objectives and activities.

Process Objective	Activities	Outcome Objective
Contractor X will provide comprehensive medical services to 100 persons living with HIV/AIDS.	At least twice a year, all clients will have complete lab	By March 31, 2012, 100% of 100 clients will have at least two medical visits with an infectious disease provider.

Activities Undertaken to Meet Objectives:
In this section you will talk about the activities you have conducted during the reporting period to meet the above process objectives. You can also discuss any outcome objectives you have completed. This section should relate back to you process objectives. Any other activities that are not related to your objectives should be reported in the highlight section. *For example, 12 clients received oral health services in the September. We have met out goal for the quarter of patients seen for services.*

Lead Agency Activities (for consortia only):
In this section you will talk about the activities you have conducted during the reporting period to meet the above process objectives. Report on quality management, and planning and evaluation activities in this section as it relates to the coordination of services for the consortium.

Quality Management:
Report on the percentage of compliance with HRSA quality indicators by running the quality indicator report in VACRS. For contractors who are funded for medical case management; please also run the case management quality indicator report in VACRS in addition to the quality indicator report.

Medication Access:
In this section please report all activities conducted to ensure clients have access to HIV-related medications. Please discuss the number of patient assistance programs (PAP) applications **completed, number of prescriptions paid for through local AIDS**

Pharmaceutical Assistance Programs and Health Insurance Premiums and Cost Sharing programs. Report any barriers that have come up in providing this service to clients.

Corrective Action (for consortia only):
In this section, discuss and update any corrective action plans established to address any performance issues with subcontractors.

Waitlist Status:
In this section, report on any wait list in the service area. Discuss the wait time for first appointments and any change in an existing waitlist. A wait list is defined as a wait time of two

weeks or more for an initial appointment. If no wait time exist but you are expecting one to occur please note the information in this section.

Service Delivery Changes:
In this section please discuss any changes to the services being delivered to clients. This includes information on additions, deletions or changes in the initial contract and work plan. If there are personnel changes please discuss them in this section.

Problems or Barriers:
In this section, please discuss any barriers or problems encountered that have occurred in administering services. If there is a plan in place to address the barriers please discuss it.

Technical Assistance:
In this section, please discuss any technical assistance request the contractor has for VDH. In addition, please update the progress of existing technical assistance being provided. For lead agencies (consortia) also discuss any technical assistance that has been provided to subcontractors or the progress of ongoing technical assistance to subcontractors.

Expenditure Table:
Use the expenditure and service table to record the actual expenses and services for the reporting period. In the first row record the month and percent of funding expended as of reporting period. This should reflect total percentage. In the services category column record the services that the contractor is funded to provide. Break services down by core medical and support services as defined by HRSA. In the first column under expenditures, record the approved budget for each service category. In the second column under expenditures record expenditures for the current reporting period only. In the third record the expenditures from beginning of the grant year to current reporting period. If not receiving administration or quality management funding, enter 0. The balance will populate for the balance.

For service units, report the projected service units for each service category in the first column under service units. In the second column under service units report the current number of units for the reporting period. In the third column, report on the number of service units from the beginning of the grant year to the current reporting period. The percent to goal will calculate automatically. Report the information utilizing the number of unduplicated clients in the unduplicated client row. Your percent to goal will populate automatically. If unable to complete the table, please provide an explanation for not completing. In addition, please provide any recommendations to assist in tracking expenditures. *See example below.*

Dec-11			83 % of funds expended									
	2011-2012 Expenditures				2011-2012 Reported Service Units				2011-2012 Unduplicated Clients			
Service Category	Budget	Current	YTD	Balance	Projected	Current	YTD	% to goal	Projected	Current	YTD	% to goal
Core Services	$220,000.00	$ 24,950.00	$183,000.00	$ 37,000.00	525	176	405	77%	525	432	500	95%
Outpat/ Ambul	$ 80,000.00	$ 15,000.00	$ 68,000.00	$ 12,000.00	250	80	200	80%	250	175	195	78%
Oral Health	$ 15,000.00	$ 950.00	$ 10,000.00	$ 5,000.00	25	6	20	80%	25	56	90	360%
Medical Case Mngm	$125,000.00	$ 9,000.00	$105,000.00	$ 20,000.00	250	90	185	74%	250	201	215	86%
Support Services	$ 75,000.00	$ 55,500.00	$ 69,500.00	$ 5,500.00	300	125	195	65%	250	182	260	104%
Medical Transport.	$ 25,000.00	$ 15,500.00	$ 22,000.00	$ 3,000.00	100	30	80	80%	50	20	35	70%
Non- Med Case Mng	$ 50,000.00	$ 40,000.00	$ 47,500.00	$ 2,500.00	200	95	115	58%	200	162	225	113%
Total:	$400,000.00	$100,450.00	$330,500.00	$ 69,500.00	825	301	600	73%	775	614	760	98%
Administration	$ 80,000.00	$ 5,000.00	$ 73,000.00	$ 7,000.00								
QM	$ 25,000.00	$ 15,000.00	$ 5,000.00	$ 20,000.00								

Report on Data Entry:

In this section, please report on the status of entering data into VACRS. Also discuss if there are any variances in the data reported in VACRS versus your internal tracking mechanism. If you have any issues with entering data please discuss those issues so they can be addressed.

Troubleshoot Tips:

- The form is an excel file. Please do not change any of the formulas in the excel spreadsheet. They have been designed to ensure accuracy.
- To start a new line within excel hit Alt + Enter within the cell.
- Use your instructions to assist with addressing all topic areas.
- Run your VACRS data on the day you complete the report to ensure a better match. Print the VACRS report and submit with your report so we are able to track any variances in data.
- For the Quality Management Indicators please run report on a calendar year for a better reflection of data.

For more information or concerns about using the program report form, please contact your contract monitor or Ms. Lenore Lombardi at Lenore.lombardi@vdh.virginia.gov or (804) 864-8022.

Contractor Report Narrative Template

Contract #		**Ryan White Part B Direct Contractor Report**
Report Month:	**Fiscal Year: 2012-2013**	
Highlights: Give an overview of Ryan White activities for the reporting period.		
Restatement of Objectives: State the objectives from work plan for the grant year.		
Activities Undertaken to Meet Objectives: Discuss the activities undertaken in the reporting period as it pertains to the above objectives. (i.e. 5 clients received medical case management services. We are now at 20% to goal for this objective.)		
Quality Management: Report on percentage of compliance with HRSA quality indicators using data from VACRS and any quality improvement activities implemented.		
Medication Access: Report all activities conducted to ensure clients have access to HIV-related medication (including PAP's, Local AIDS Pharmaceutical Assistance Program) You may include the amount of time spent on medication access activities.		
Waitlist Status: Please report any waitlist for services, first appointments, and/or any changes in wait lists experienced. A waitlist is defined as a wait time of two weeks or more for an initial appointment.		

Service Delivery Changes: Please discuss any additions, deletion or other changes in service provisions, including personnel.

Problems or Barriers Encountered: Discuss any barriers encountered in the reporting month.

Technical Assistance: Please discuss any technical assistance needs the agency has for VDH.

In the table below, attempt to report expenditures for funded service categories for FY 2011. To calculate the expenditures utilize the budget submitted to VDH with contract. Based on data submitted to VACRS, complete the table below with each service category you are funded to conduct. Report your projected number of clients served and service units. Please report the actual number served and service units in the reporting month. If unable to complete the table, please provide an explanation for not completing the table.

Expenditure Status: Report any significant under or over expenditures during the reporting period. Any invoice issues should be noted here.

As of		% of funds expended							

Service Category	2011-2012 Expenditures				2011-2012 Reported Service Units				2011-2012 Unduplicated Clts			
	Budget	Current	YTD	Balance	Projected	Current	YTD	% to goal	Projected	Current	YTD	% to goal
Core Services	$0.00	**$0.00**	**$0.00**	**$0.00**	0	0	0	#DIV/0!	0	0	0	#DIV/0!
				$0.00				#DIV/0!				#DIV/0!
				$0.00				#DIV/0!				#DIV/0!
Support Services	**$0.00**	**$0.00**	**$0.00**	**$0.00**	0	0	0	#DIV/0!	0	0	0	#DIV/0!
				$0.00				#DIV/0!				#DIV/0!
				$0.00				#DIV/0!				#DIV/0!
				$0.00				#DIV/0!				#DIV/0!
				$0.00				#DIV/0!				#DIV/0!
				$0.00				#DIV/0!				#DIV/0!
Total:	$0.00	$0.00	$0.00	$0.00	0	0	0	#DIV/0!	0	0	0	#DIV/0!
Administration				$0.00								
QM				$0.00								

Report on the status of VACRS data entry and any problems encountered in interfacing with the data system:

Please discuss any variances in projected numbers versus actual (i.e. may not meet or exceed service units or clients served)

VIRGINIA DEPARTMENT OF HEALTH
ADAP MEDICATION EXCEPTION FORM

PATIENT NAME (Last, First, MI):			
D.O.B. (mm/dd/yy):	**AGE:**	**SEX:** ☐ **MALE**	☐ **FEMALE**
ADDRESS	**CITY**	**STATE**	**ZIP**
RACE/ETHNICITY: ☐ White (non-Hispanic) ☐ African American/Black (non-Hispanic) ☐ Hispanic ☐ Asian/Pacific Islander ☐ American Indian, Aleutian, Eskimo ☐ Unknown			
HEALTH DEPARTMENT PHONE #		**HEALTH DEPARTMENT FAX #**	
LOCAL HEALTH DEPARTMENT ADAP CONTACT PERSON:			
PRESCRIBING PHYSICIAN NAME:			
PHYSICIAN PHONE #:		**PHYSICIAN FAX #:**	
FORM COMPLETED BY (Name):			
TITLE:		**DATE (mm/dd/yy):**	

MEDICATION REQUESTED:
REASON FOR EXCEPTION REQUEST (PLEASE REFER TO EXCEPTION CRITERIA):

Specify other anti-retroviral medications patient is currently on

NAME OF MEDICATION	DOSE	DATE STARTED	DATE DISCONTINUED

LABORATORY HISTORY (Please start with the most current results (give at least two (2) results if available))

VIRAL LOAD RESULTS*	DATE	CD4 COUNT RESULTS	DATE

VDH USE ONLY

☐ **Request Approved** ☐ **Request Denied**

Rationale:_____

_____

Signature:_____ **Date:**_____

Date of Positive CCR5 assay/Maraviroc Approval: _____

Fax to: Central ADAP office at (804) 864-8050 [Phone: (855) 362-0658]

Revised 09/2012

COOP RESOURCE LIST

If you would like specific information about developing a COOP, these sites are good places to start:

ADAP Emergency Preparedness Guide
www.nastad.org
American Medical Association (AMA)
http://www.ama-assn.org
American Medical Association Center for Public Health Preparedness and Disaster Response
http://www.ama-assn.org
American Red Cross Disaster Services
http://www.redcross.org/services/disaster
http://www.redcross.org
Are You Ready? An In-depth Guide to Citizen Preparedness
http://www.fema.gov/areyouready/index
ASTHO
http://www.astho.org/programs/preparedness
Centers for Disease Control and Prevention Emergency Preparedness and Response
http://www.bt.cdc.gov
Emergency Email and Wireless Network Notification System
http://www.emergencyemail.org
Emergency Management Assist Compact
www.emacweb.org
FEMA Preparedness Presentation
http://www.fema.gov/pdf/areyouready/index
FEMA Preparedness and Training
http://www.fema.gov/government/prepare
FEMA Risk Assessment Form
http://www.fema.gov/areyouready/getting_informed
FEMA State Offices and Agencies of Emergency Management http://www.fema.gov/regional-operations/state-offices-and-agencies-emergency-management
HAZUS Risk Assessment Software
http://www.fema.gov/hazus
HRSA Emergency Planning
http://www.hrsa.gov/emergency
NACCHO
http://www.naccho.org/topics/emergency
Pandemic Flu
http://www.flu.gov
Ready America: Prepare, Plan and Stay Informed
http://www.**ready**.gov
Continuity of Operations Part 1 and Continuity of Operations Conclusion
http://va.train.org

VIRGINIA RYAN WHITE PROGRAMS

Ryan White Part	Site	City
A Metro Area	Norfolk Transitional Grant Area (TGA)	Norfolk
A Metro Area	Washington, DC Eligible Metropolitan Area (DC EMA)	Washington DC/Northern Virginia
B State	Virginia Department of Health	Richmond
C Early Intervention	Carilion Medical Center	Roanoke
C Early Intervention	Centra Health, Inc.	Lynchburg
C Early Intervention	Eastern Virginia Medical School	Norfolk
C Early Intervention	Inova Health Care Services	Alexandria
C Early Intervention	Mary Washington Hospital/Medicorp Health System	Fredericksburg
C Early Intervention	University of Virginia	Charlottesville
C Early Intervention	Virginia Commonwealth University	Richmond
D Women, Infants, Children, Youth	INOVA Health Care Services	Alexandria
D Women, Infants, Children, Youth	University of Virginia	Charlottesville
F AIDS Education and Training Center Pennsylvania/Mid-Atlantic AETC	Virginia Commonwealth University INOVA Health System	Richmond Fairfax

RYAN WHITE PART A AND PART B FUNDABLE PROGRAM SERVICES LIST

Part A and Part B Allowable Program Services	
Core Medical Services	
a.	Outpatient /Ambulatory health services
b.	AIDS Drug Assistance Program (ADAP) treatments
c.	AIDS Pharmaceutical Assistance (local)
d.	Oral health care
e.	Early Intervention Services
f.	Health Insurance Premium & Cost Sharing Assistance
g.	Home health care
h.	Home and Community-based Health Services
i.	Hospice Services
j.	Mental health services
k.	Medical Nutrition Therapy
l.	Medical Case Management (including Treatment Adherence)
m.	Substance abuse services–outpatient
Support Services	
n.	Case Management (non-Medical)
o.	Child care services
p.	Pediatric developmental assessment and early intervention
q.	Emergency financial assistance
r.	Food bank/home-delivered meals
s.	Health education/risk reduction
t.	Housing services
u.	Legal services
v.	Linguistics Services
w.	Medical Transportation Services
x.	Outreach services
y.	Permanency Planning
z.	Psychosocial support services
aa.	Referral for health care/supportive services
ab.	Rehabilitation services
ac.	Respite care
ad.	Substance Abuse Services-residential
ae.	Treatment adherence counseling

NOTE: **Ryan White Part A and Part B grant funds may be used to support ONLY the service categories listed above**. The *Ryan White Program Service Category Definitions* list includes additional categories that are fundable under Ryan White Part C and/or Part D only.

RYAN WHITE PROGRAM SERVICE DEFINITIONS

CORE SERVICES

Service categories:

a. ***Outpatient/Ambulatory medical care (health services)*** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. **NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here under *Outpatient/ Ambulatory medical care*.**

b. ***AIDS Drug Assistance Program (ADAP treatments)*** is a State-administered program authorized under Part B of the Ryan White Program that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.

c. ***AIDS Pharmaceutical Assistance (local)*** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are **not** funded with ADAP earmark funding.

d. ***Oral health care*** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

e. ***Early intervention services (EIS)*** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

NOTE: EIS provided by Ryan White Part C and Part D Programs should NOT be reported here. Part C and Part D EIS should be included under *Outpatient/ Ambulatory medical care*.

f. ***Health Insurance Premium & Cost Sharing Assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

g. ***Home Health Care*** includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, diagnostic testing, and other medical therapies.

h. ***Home and Community-based Health Services*** include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are **NOT** included.

i. ***Hospice services*** include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

j. ***Mental health services*** are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

k. ***Medical nutrition therapy*** is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

l. ***Medical Case management services (including treatment adherence)*** are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

m. ***Substance abuse services outpatient*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

SUPPORT SERVICES

n. ***Case Management (non-Medical***) includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

o. ***Child care services*** are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training.

NOTE: This does not include child care while a client is at work.

p. ***Pediatric developmental assessment and early intervention services*** are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category.

q. ***Emergency financial assistance*** is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

NOTE: Part A and Part B programs must be allocated, tracked and report these funds under specific service categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formally Policy No. 97-02).

r. ***Food bank/home-delivered meals*** include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

s. ***Health education/risk reduction*** is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

t. ***Housing services*** are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

u. ***Legal services*** are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

v. ***Linguistics services*** include the provision of interpretation and translation services.

w. ***Medical transportation services*** include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

x. ***Outreach services*** are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in, care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

y. ***Permanency planning*** is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

z. ***Psychosocial support services*** are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

aa. ***Referral for health care/supportive services*** is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.

ab. ***Rehabilitation services*** are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

ac. ***Respite care*** is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.

ad. ***Substance abuse services–residential*** is the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

ae. ***Treatment adherence counseling*** is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

Virginia Department of Health
HIV Care Services
Service Unit Definitions

Fiscal Year 2013-2014	
1. HRSA Service Categories:	**2. Service Unit Definition:** Define the service unit to be provided
1. Core Medical Services	
a. Outpatient /Ambulatory Health Services	One or more medical visits per day at the same practice/site =one unit*
a1. Laboratory Test	One lab = one unit
b. AIDS Drug Assistance Program (ADAP treatments)	
c. AIDS Pharmaceutical Assistance (local)	A 30 day or less prescription= one unit
d. Oral Health Care	One visit = one unit
e. Early Intervention Services	One testing or referral = one unit
f. Health Insurance Premium & Cost Sharing Assistance	One premium or copayment payment = one unit
g. Home and Community-Based Health Services	One in-home visit by medical or support staff = one unit.
h. Mental Health Services	One or more visits per day = one unit*
i. Medical Nutrition Therapy	One case of supplement or visit with registered dietician=one unit
j. Medical Case Management (including Treatment Adherence)	1 – 15 minute encounter with case manager (1 hour = 4 units)
k. Substance Abuse Services–outpatient	One or more visits per day = one unit*

NOTE: A very limited number of contractors are funded under one or more support services. Please do not utilize these categories or enter them into VACRS (CAREWare) unless you are funded under one of these categories for 2012-2013	
2. Support Services	
a. Case Management (non-Medical)	1 – 15 minute encounter with case manager (1 hour = 4 units)
b. Child Care Services	One or more services to children of HIV + individuals per day = one unit***
c. Emergency Financial Assistance	1 service assistance (i.e. a payment for rent) = 1 unit
d. Food Bank/Home-Delivered Meals	One bag of food, voucher to food pantry, or delivered meal, one case of nutritional supplement = one unit**
e. Health Education / Risk Reduction	1 organized effort = one unit
f. Linguistic Services	One provided linguistic service = one unit****
g. Medical Transportation Services	A one way trip = one unit. One voucher = one unit (CAREWare to track $ value)
h. Outreach Services	1 – 15 minute face to face outreach visit = one unit
i. Psychosocial Support Services	one visit = one unit
j. Substance Abuse Services – Residential	one day of treatment = one unit
k. Treatment Adherence Counseling	one visit = one unit

*An additional visit on the same date of service at a different practice/site = one unit. All categories assume one or more client encounters per day with the same practice/site = one unit.
** In accordance the provision of Medical Nutritional Therapy must be conducted by a registered dietitian. Issuing nutritional supplements without a dietician falls under food bank and home delivered meals.
*** Child care services are those provided to children of clients who are HIV+ while the client attends medical or other appointments or Ryan White Program related meetings, groups, or training.
**** Linguistic services include oral or written translation for a client to assist with language barriers.
Final Report Prepared by NVRC Staff 11/4/11

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Assurances
Non Allowable Use of Ryan White Funds

Below is a list of all non-allowable uses of Ryan White Funding. Contractors please sign and date this list assuring VDH that no Ryan White funds have been used to either purchase the following items or engage in the following activities.

Unallowable Purchases*:*

- Clothing
- Funeral, burial, cremation or related expenses
- Local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied)
- Household appliances
- Pet foods or other non-essential products
- Off-premise social/recreational activities or payments for a client's gym membership
- Purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility
- Pre-exposure prophylaxis
- Inpatient hospital services, or nursing home or other long-term care facilities
- Purchase vehicles
- Foreign Travel
- Cost associated with the creation, capitalization, or administration of a liability risk pool (other than those costs paid on behalf of individuals as part of premium contributions to existing liability risk pools), or to pay any amount expended by a State under Title XIX of the Social Security Act

Unallowable Activities:

- *Use of funds for cash payments to service recipients
- Develop materials designed to promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual
- Non-targeted marketing promotions or advertising about HIV services that target the general public (poster campaigns for display on public transit, TV or radio public service announcements, etc.)
- Broad-scope awareness activities about HIV services that target the general public, outreach activities that have HIV prevention education as their exclusive purpose.
- Influencing or attempting to influence members of Congress and other Federal personnel.

*Note: A cash payment is the use of some form of currency (paper or coins) Gift cards have an expiration date; therefore they are not considered to be cash payments.

_____
Name of Organization

_____
Contractor Signature and Title

_____ _____
Contractor Print Name Date

Data Security and Confidentiality Guidelines
Division of Disease Prevention
Virginia Department of Health - Office of Epidemiology

Certificate of Receipt

Your signature below indicates your receipt of the Virginia Department of Health - Division of Disease Prevention *Data Security and Confidentiality Guidelines.*

Your signature does not imply agreement or disagreement with the guidelines; however, all employees, contractors, and/or data recipients are required to comply with these Guidelines.

Name *(print)*:_____

Signature:_____ **Date:**_____

Supervisor's Signature:_____ **Date:**_____

Virginia Department of Health – Division of Disease Prevention
Data Security and Confidentiality Guidelines
Revision Date 11/24/2009

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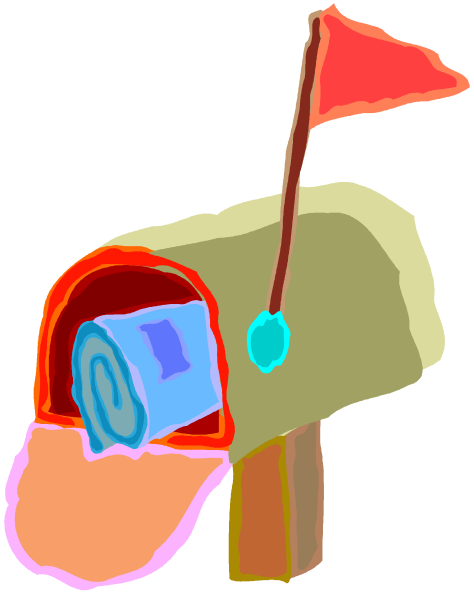
HIV CARE SERVICES CONTRACTOR GUIDELINES 2013

Certificate of Receipt



Your signature below indicates your receipt of the Virginia Department of Health, Division of Disease Prevention, HIV Care Services *CONTRACTOR GUIDELINES*.

Your signature does not imply agreement or disagreement with the guidelines; however, all contractors and subcontractors are required to comply with these guidelines.

NAME
(*Print*):_____AGENCY: _____

SIGNATURE: _____ DATE: _____